Appendix 2

UB-92 Claim Form Instructions

Use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless "not required" is specified.

These instructions will help you complete a UB-92 claim only for Wisconsin Medicaid. For complete billing instructions, refer to the UB-92 Billing Manual prepared by the State Unified Billing Committee (SUB-C). The UB-92 Billing Manual contains important coding information not available in this appendix. You may purchase the UB-92 Billing Manual by writing to:

Wisconsin Health and Hospital Association
5721 Odana Road
Madison, Wisconsin 53719-1289
(608) 274-1820

Wisconsin Medicaid recipients receive a plastic identification card (the Forward card) when initially enrolled in Wisconsin Medicaid. Always see this card before providing services. Please use the information exactly as it appears on the ID card to complete the patient information.

Item 1: Provider Name, Address, and Telephone Number
Enter the name, address, city, state and ZIP code of the billing provider.

Item 2: Unlabeled Field (not required)

Item 3: Patient Control Number (not required)
Providers may enter the patient's internal office account number. This number will appear on the Wisconsin Medicaid fiscal agent Remittance and Status Report (maximum of 17 characters for paper, electronic, or tape claims).

Item 4: Type of Bill
Enter the 3-digit code indicating the specific type of claim. The first digit identifies the type of facility. The second digit classifies the type of care. Personal care/home health providers are required to use bill type 33X. The third digit ("X") indicates the billing frequency and should be assigned as follows (331, 332, 333, or 334):

1 = Inpatient admit through discharge claim
2 = Interim bill - first claim
3 = Interim bill - continuing claim
4 = Interim bill - final claim

Item 5: Federal Tax Number (not required)

Item 6: Statement Covers Period (from - through) (not required)

Item 7: Covered Days (not required)

Item 8: Noncovered Days (not required)

Item 9: Coinsurance Days (not required)

Item 10: Lifetime Reserve Days (not required)

Item 11: Unlabeled Field (not required)

Item 12: Patient Name
Enter the recipient's last name, first name, and middle initial exactly as it appears on the plastic Wisconsin Medicaid identification card (the Forward card), including spaces and hyphens.

Item 13: Patient's Address (not required)

Item 14: Patient's Date of Birth (not required)

Item 15: Patient's Sex (not required)

Item 16: Marital Status (not required)

Item 17: Date of Admission (not required)

Item 18: Hour of Admission (not required)

Item 19: Type of Admission (not required)

Item 20: Source of Admission (not required)

Item 21: Discharge Hour (not required)

Item 22: Patient Status (not required)

Item 23: Medical/Health Record Number (optional)
This number will not appear on the Remittance and Status Report.

Items 24-30: Condition Codes (Required, if applicable.)

Code	Explanation of Code
01	*Military service related:* Medical condition incurred during military service.
02	*Condition is employment related:* Patient alleges that medical condition is due to environment/events resulting from employment.
03	*Recipient covered by insurance not reflected here:* Indicates that the patient or a representative has stated that coverage may exist beyond that reflected on this bill.
05	*Lien has been filed:* Provider has filed legal claim for recovery of funds potentially due a recipient as a result of legal action initiated by or on behalf of the patient.
08	*Beneficiary would not provide information concerning other insurance coverage:* Enter this code if the beneficiary would not provide information concerning other insurance coverage.

See UB-92 Billing Manual for additional codes.

Items 32-35(a-b): Occurrence Codes and Dates (Required, if applicable.)
If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. All dates are required to be printed in the MMDDYY format.

Code	Explanation of Code
01	*Auto Accident:* Code indicating the date of an auto accident.
02	*Auto Accident/No Fault Insurance:* Code indicating the date of an auto accident where the state has applicable no-fault liability laws.
03	*Accident/Tort Liability:* Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	*Accident/Employment Related:* Code indicating the date of an accident relating to the patient's employment.
05	*Other Accident:* Code indicating the date of an accident not described by the above codes.
06	*Crime Victim:* Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
25	*Date Benefits Terminated by Primary Provider:* Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
42	*Date of Discharge:* For final bill of hospice care, enter the date the beneficiary terminated the election of hospice care.

See UB-92 Billing Manual for additional codes.

Item 36(a-b): Occurrence Span Code and Dates (not required)

Item 37: Internal Control Number (ICN)/Document Control Number (DCN) (not required)

Item 38: Responsible Party Name and Address (not required)

Items 39-41(a-d): Value Codes and Amounts (Required, if applicable.)
If appropriate, enter a value code and the related dollar amount necessary for processing this claim. The value code structure is intended to provide additional reporting capabilities.

Code	Explanation of Code
22	*Surplus:* Spenddown required to be entered if patient spenddown occurs. This code should be entered together with the dollar amount.

Item 42: Revenue code
Enter revenue code 001on the last line, indicating the line on which the sum of all charges on the claim is placed.

Item 43: Revenue Description
Enter the date of service in the MMDDYY format either in this item or in Item 45.

When series billing (i.e. billing from two to four dates of service on the same line), indicate the dates of service in the following format: MMDDYY MMDD MMDD MMDD. Indicate the dates in ascending order.

Providers may enter up to four consecutive dates of service for each revenue or procedure code if:

- All dates of service are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.

If it is necessary to indicate more than four dates of service per procedure code, indicate the dates on subsequent lines. On paper claims, no more than 23 lines may submitted on a single claim, including the "total charges" line.

Item 44: HCPCS/Rates
Enter the appropriate five-digit procedure code.

Item 45: Service Date
Enter the date of service in the MMDDYY format either in this item or in Item 43 (multiple dates of service are required to be indicated in Item 43).

Item 46: Units of Service
Enter the total number of services billed on each line item.

Item 47: Total Charges (by revenue code category)
Enter the total charge for each line item. For revenue code 001 (total charges), enter the grand total for all services submitted on the claim.

Item 48: Noncovered Charges (not required)

Item 49: Unlabeled Field (not required)

Item 50: Payer Identification
Indicate Medicaid ("T19-WI Medicaid") and all third-party payers (including Medicare) with possible involvement in this claim. All coverages indicated on the recipient's Medicaid identification card must be addressed.

Item 51: Provider Number
Enter the provider's eight-digit provider number on line B.

Item 52: Release Information Certification Indicator (not required)

Item 53: Benefits Assigned (not required)

Item 54: Prior Payments-Payer and Patient (Required, if applicable.)
If applicable, enter the amount the provider has received toward payment of this bill prior to the billing date by the indicated payer. If "other insurance" denied the claim, enter $0.00 (do not indicate Medicare payment).

Item 55: Estimated Amount Due (not required)

Item 56: Unlabeled Field (not required)

Item 57: Unlabeled Field (not required)

Item 58: Insured's Name (not required)

Item 59: Patient's Relationship to Insured (not required)

Item 60: Certification Number, Social Security Number, Health Insurance Claim Number Identification Number
On line B, enter the recipient's 10-digit Medicaid ID number as it appears on his or her Forward card.

Item 61: Insured Group Name (not required)

Item 62: Insurance Group Number (not required)

Item 63: Treatment Authorization Code
On line B, enter the seven-digit prior authorization number from the approved Prior Authorization Request Form. Services authorized under separate prior authorization numbers are required to be billed on separate claim forms with their respective prior authorization numbers.

Item 64: Employment Status Code (not required)

Item 65: Employer Name (not required)

Item 66: Employer Location (not required)

Item 67: Principal Diagnosis Code
The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code is required to be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. Manifestation ("M") codes are not valid diagnosis codes for Wisconsin Medicaid.

Items 68-75: Other Diagnosis Codes
Enter the full ICD-9-CM diagnosis codes corresponding to additional conditions related to treatment billed on the claim. Other diagnosis codes will permit the use of ICD-9-CM "E" codes. Manifestation ("M") codes are not valid diagnosis codes for Wisconsin Medicaid.

Item 76: Admitting Diagnosis (not required)

Item 77: External Cause of Injury (E-Code) (not required)

Item 78: Race/Ethnicity (not required)

Item 79: Procedure Coding Method Used (not required)

Item 80: Principal Procedure Code and Date (not required)

Item 81: Other Procedure Codes and Dates (not required)

Item 82(a-b): Attending Physician ID (not required)

Item 83(a-b): Other Physician ID (not required)

Item 84: Remarks (Enter information when applicable.)
Private Insurance
Third-party insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave Item 84 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, ***and*** the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December 1998 (No. 98-38), then one of

the following three other insurance (OI) explanation codes ***is required to*** be indicated in the ***first*** box of Item 84. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by health insurance. In Item 54 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: • Recipient denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • Health insurance failed to respond to initial and follow-up claims. • Benefits not assignable or cannot get assignment.

When the recipient is a member of an HMO, one of the following must be indicated, ***if applicable***:

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Medicaid for services which are included in the capitation payment.

Medicare

Medicare codes cannot be used if one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.
The following Medicare disclaimer codes can be used when appropriate.

Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B, but is not payable due to benefits being exhausted.

M-5 Provider is not Medicare certified. This code can be used when providers are identified in Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code 585) because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Item 85 - Provider Representative Signature

The provider or the authorized representative is required to sign in Item 85. This may be a computer printed name or a signature stamp.

Item 86 - Date Bill Submitted

Enter the date on which the claim is submitted to Wisconsin Medicaid in the MMDDYY format.